UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

SELZENTRY (maraviroc)

Patient name:_____Medicaid or SS#_____

Physician Name:_____ Contact person:_____

Phone#:_____Ext. and opt._____Fax#_____

Pharmacy_____Pharmacy Phone#:_____

All information to be legible, complete and correct or form will be returned

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FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF MEDICAL NECESSITY TO (801) 536-0477

CRITERIA:

- Minimum age: 16 years old.
- Documentation of a co-receptor tropism assay test indicating CCR5-tropic HIV-1 infection.
- Documentation of optimized background therapy for the treatment of HIV-1 infection.

AUTHORIZATION:

1 year

RE-AUTHORIZATION:

Telephone call from physician office or pharmacy

4/8/8